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CLINICAL ASPECTS OF DIAGNOSIS AND TREATMENT OF ADDICTIONS*

By ABRAHAM WIKLER, M.D.†

For clinical purposes, "drug addiction" may be defined as the *compulsive* use of chemical agents which are *harmful* to the individual, to society, or to both. In this sense, the most common addictions encountered in clinical practice in the United States are those to the opiate-like drugs (opium and its derivatives, and the newer synthetic potent analgesic agents), barbiturates, alcohol, marihuana and cocaine. In patients addicted to opiate-like drugs and the barbiturates, abrupt withdrawal of the drug in question is followed by distressful, though self-limited changes in the organism which can be described in physiological terms ("physical dependence"). Very likely this is also true of alcohol addiction (delirium tremens). No significant physiological changes have yet been demonstrated during abstinence following abrupt withdrawal of marihuana and cocaine in patients addicted to these drugs.

Because of their clinical importance, only addictions to the opiate-like drugs and the barbiturates will be considered here. Addiction to alcohol is obviously a serious clinical problem but will not be discussed since systematic studies on alcoholism have not been made in this laboratory. Addiction to cocaine entails serious consequences to the user and to society. However, most cocaine users sooner or later employ opiate-like drugs to counterbalance the excessively stimulating effects of cocaine, and eventually become addicted to the opiate-like agents. Addiction to marihuana is of clinical importance because it may lead to the more serious addictions to opiate-like drugs through the degrading social contacts with which the use of marihuana is associated in our culture.

* Presented at a staff forum of the Menninger Foundation and Winter VA Hospital, Topeka, Kansas, March 15, 1951.

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Addiction to Opiate-like Drugs

DIAGNOSIS

Presumptive evidence that a patient has used drugs sometime in the past may be afforded by the detection of needlemarks and phlebitic scars. Needlemarks are usually pinhead-sized bluish discolorations of the skin and phlebitic scars are similarly colored, due to adulterants which are commonly contained in narcotics derived from illegal sources. That the patient has been using opiate-like drugs recently may be suggested by the presence of miosis and proved by the detection of opiates in the urine by chemical methods.

Proof of addiction to opiate-like drugs can be obtained only by observation of the characteristic withdrawal syndrome which follows *abrupt* and *complete* withdrawal of drugs. The clinical features and the intensity of the abstinence syndrome which then ensues depends on various factors, of which the most important are the nature of the drug used by the patient, the dose to which he has been accustomed, the duration of addiction and individual differences. However, a description of the complete abstinence syndrome which follows abrupt withdrawal of morphine will serve the purpose of illustrating its general features.

The organismal changes which characterize the morphine abstinence syndrome may be classified into two groups: non-purposive and purposive, both of which appear to be partly "unconditioned" and partly "conditioned" in man. The non-purposive changes include diffuse anxiety; disturbances in sleep; restlessness; generalized muscular aching; typical facies; a tendency to lie on one side, preferably on a hard cold floor in a curled-up position with blankets drawn up over the head (even on hot summer days); sensations of hot and cold flashes; occasional ejaculations; mydriasis; lacrimation; rhinorrhea; gooseflesh; sweating; muscle twitches, especially in the legs (hence the addict's term "kicking the habit"); fever; elevation of blood pressure, pulse and respiratory rate (often with "air hunger"); nausea, vomiting and diarrhea; anorexia, and weight loss (as much as 22 pounds in three days). In addition, leukocytosis, precipitous drop in circulating blood eosinophile count, hyperglycemia and elevation of the basal metabolic rate may be observed. The purposive abstinence changes include intense craving for narcotic drugs, demanding and pleading for the same, and types of behavior which are designed to achieve this end, the patterns of which depend on the personality of the individual, of the physician and the setting in which the abstinence syndrome occurs.

In untreated cases, the morphine abstinence syndrome becomes clearly evident about 14 to 20 hours after the last dose of the drug. Its intensity reaches a peak between the 48th and 72nd hours of withdrawal, then di-

minishes rapidly during the next 5 to 10 days and is largely dissipated after two weeks. However, deviations from control values of physiologic variables may be detected for as long as six months after withdrawal. If a stabilization dose of morphine (the minimum amount of the drug needed to suppress abstinence deviations during addiction) is administered to the patient during the acute phase of the abstinence syndrome, the changes described undergo a dramatic reduction in intensity for 6 to 12 hours, and the duration of the syndrome is not prolonged. This fact may be utilized as confirmatory evidence that the clinical picture is actually that of the opiate abstinence syndrome, and is also the basis of some methods of treatment.

The reliability of a method for demonstrating abstinence changes more rapidly is currently under investigation at the Lexington Hospital. This is based on the observation that in addicted patients, a typical abstinence syndrome may appear within 20 to 30 minutes after a single subcutaneous injection of N-allylnormorphine in an amount which is as little as one-tenth the regular dose of morphine to which the patient has been accustomed. N-allylnormorphine appears to antagonize the narcotic effects of morphine, yet it either "unmasks" or potentiates the organismal changes which subserve the morphine abstinence syndrome.

Although a fairly predictable relationship between addiction dosage and intensity of the morphine abstinence syndrome has been demonstrated in patients with previous histories of drug addiction ("post-addicts") who volunteer for research studies, considerable variation is observed clinically in unselected subjects. Even when a group of patients has been stabilized on the same daily dosage of morphine, some individuals will manifest all of the changes described above, while in others, only some mydriasis and gooseflesh can be demonstrated. However, experimental studies have shown that the individual peculiarities of the morphine abstinence syndrome are regularly reproducible in the same person after repeated addictions and withdrawals (abrupt).

The general features of the morphine abstinence syndrome are also characteristic of opium, heroin, dilaudid and pantopon. That produced by heroin is usually more severe, while the dilaudid abstinence syndrome is more rapid in onset and is dissipated more quickly. The meperidine ("demerol") abstinence syndrome is less severe than that of morphine, and the codeine abstinence syndrome is relatively mild. The abstinence syndrome following abrupt withdrawal of methadone ("amidone," "dolophine," "10820") is characterized by slow onset, a paucity of measurable objective signs (which reach a peak at about the 5th day of withdrawal), and long persistence of weakness, irritability, reduced appetite and sleep. The relative mildness of the methadone withdrawal syndrome is utilized in some forms of treatment, although some addicts regard the prolonged, though moderate, dis-

comforts attendant on methadone withdrawal as more objectionable than the more severe, but shorter lasting disturbances which are experienced during morphine withdrawal.

TREATMENT

Rational therapy presupposes a thorough understanding of both the physiologic and psychodynamic aspects of the addiction process, which have been discussed in detail elsewhere (see Bibliography). Some of the therapeutic problems in drug addictions can best be treated by pharmacologic means, while others are more amenable to psychotherapy. Both have an important place in all stages of treatment.

In general, the treatment of addicted patients may be divided into two stages. First, withdrawal of the drug and second, rehabilitation. For success in both phases of treatment, the patient should be hospitalized in an institution with adequate, specialized facilities for control of contraband narcotics. In addition to thorough physical and psychiatric examinations, careful yet tactful search should be made for concealed drugs on admission. Addicts have been known to conceal drugs in the nasal cavities, dentures, the external ear, the rectum, the vagina or in rubber finger cots which are swallowed and later eliminated by vomiting, or in the stool. Drugs may also be concealed in fountain pens, cigars, cigarettes, lighters, canes, shoes or other articles of clothing. Narcotics may reach hospitalized patients through the mails, in various ways. Hospitalization is also of value in providing a situation in which some of the environmental factors that contributed to addiction have been eliminated. However, hospitalization also has drawbacks. The rigid, routinized, childhood-level type of existence which characterizes life in most institutions may be acceptable to infantile persons, but constitutes an additional stress for more mature individuals. Prolonged hospitalization tends to foster dependency, and a "good institutional adjustment" may therefore entail a poor prognosis for adaptation in a competitive society in some individuals. From statistical data acquired in recent years at the United States Public Health Service Hospital at Lexington, Kentucky, it appears that optimum results are obtained when patients are hospitalized for about four to six months, but the exact period should be determined, as far as possible, on an individual basis.

Withdrawal of Drugs

Of the numerous methods of withdrawing narcotic drugs, only two are worthy of discussion. The older method is that of stabilization on a dosage schedule of morphine which is just sufficient to repress withdrawal signs, followed by rapid reduction of the dose over a period of seven to ten days. The amount needed to achieve stabilization varies considerably but usually

30 milligrams of morphine administered every six hours is sufficient regardless of the dosage to which the patient has been accustomed. Sometime this dose is high and signs of morphine poisoning may appear, particularly if the patient has grossly exaggerated the amount of drugs he has been using. This syndrome is characterized by coma, miosis, and signs resembling those of surgical shock—pallor, sweating, and decrease in rate and amplitude of respirations, except that cardiac rate is usually slowed, rather than accelerated. Artificial respiration by means of a mechanical resuscitator and an air-way should be instituted immediately. Intravenous or intramuscular injections of coramine, caffeine and/or ephedrine should also be administered. If the patient does not respond to such treatment, N-allylnormorphine may be given subcutaneously, in amounts equal to half the estimated total dose of morphine which had been taken by the patient that day. If this is unknown, 15 milligrams of N-allylnormorphine may be administered, and this dose may be repeated in one hour if necessary. Recent studies have shown that N-allylnormorphine is a specific antagonist, not only for morphine, but also for methadone, a new synthetic analgesic whose pharmacologic actions are very similar to those of the opiates.

After three days on such stabilization doses of morphine, the latter may be reduced rapidly, either in successive doses or on successive days, until a level of 10 milligrams is reached, when such injections of morphine may be alternated with 30 milligrams of codeine for one day. Codeine alone may then be continued for two or three days, after which all drugs are discontinued. One, or at most, two "pickup" injections of 10 milligrams of morphine may be given during the subsequent week if weakness, anorexia and insomnia persist. In addition, flow baths are useful for sedation, acetylsalicylic acid for muscular pains and intravenous or subcutaneous injections of glucose in saline, or saline alone, for dehydration. Barbiturates may be prescribed to promote sleep, but should be used sparingly, except when addiction to opiate drugs has been complicated by chronic barbiturism (see below).

In recent years, the methadone substitution method has been employed with success at the Lexington Hospital. After three days stabilization on morphine, methadone is substituted in the ratio of about 1 milligram of methadone for three milligrams of morphine and the patient is stabilized on methadone for 7 days, after which it is reduced rapidly over a period of four days. For example, if a patient has been stabilized on 30 milligrams of morphine four times daily, substitution of methadone may be made in one day by administering 30 milligrams of morphine and 10 milligrams of methadone as the first dose; 20 milligrams of morphine and 10 milligrams of methadone as the second; 10 milligrams of morphine and 10 milligrams of methadone as the third; and 10 milligrams of methadone alone as the

final dose for the day. For seven days thereafter, 10 milligrams of methadone may be administered four times daily. Then the total daily dose of methadone may be reduced so that the patient receives a total of 30 milligrams on the first day of reduction, 25 milligrams on the second, 20 milligrams on the third, and finally, 8 milligrams on the fourth; "pickup" injections and adjuvant treatments may be administered as described above.

It should be emphasized that such schedules are not applicable to all cases and that modifications may be permitted when, in the physician's judgment, they are indicated. Extreme caution should be exercised in withdrawing drugs from patient with evidence of myocardial insufficiency. While withdrawal of drugs may be accomplished with safety in most individuals, occasionally it will be necessary to continue administration of small maintenance doses of narcotics for an indefinite period to prevent congestive failure. In patients with active pulmonary tuberculosis, withdrawal of drugs should be spread over a period of about one month. It is useless to attempt complete withdrawal of narcotics in patients with chronic continuous intractable pain, until suffering is relieved by other measures. In such patients, the dose of morphine may be reduced to the minimum level needed to alleviate pain, and then substitution with a new synthetic analgesic agent, alpha-acetylmethadol (levorotatory) may be made. This drug, a derivative of methadone, may be administered once daily orally, in a dose of 1 milligram of the compound for about 6 milligrams of morphine. Alpha-acetylmethadol (levorotatory) has a very prolonged action, and when it is used, the patient should be observed carefully for cumulative depressant effects. Its exact analgesic potency has not yet been assayed but in the ratio mentioned, this drug suppresses morphine abstinence signs effectively, and on abrupt withdrawal, the ensuing abstinence syndrome is similar to that of methadone. In patients with recurrent, severe, but short-lasting pains, such as those of the various neuralgias and tabetic orises, the use of narcotics with long-lasting effects, or repeated regular doses of shorter acting narcotics is not desirable. The ideal analgesic for such patients would be one with high pain-relieving properties but short duration of action and minimal abstinence-change producing power. Such a drug is not yet available, but meperidine meets these criteria fairly well.

It may be noted here that evaluation of pain in addicts is not easy. While intense pain, or at least intense suffering, may be experienced in the absence of demonstrable pathology, the physician has to rely on his diagnostic acumen in determining whether adequate cause for pain exists. On the other hand, because of the very nature of the pain experience, no technics are as yet available to measure the intensity of another person's suffering. If, therefore, the physician is satisfied that adequate cause for pain exists, effective doses of analgesics should be administered until the

source of pain is remedied by appropriate treatment. Above all, the physician's judgment should not be influenced unduly by his personal reaction to the manner in which the patient expresses his complaints.

During the past few years a number of investigators have observed that bilateral frontal lobotomy reduces markedly the craving for narcotics in addicted patients, although the physiological changes which ensue after abrupt withdrawal of drugs may be unaltered. While this operation may be indicated in some patients who suffer from intractable pain with or without addiction to narcotics, frontal lobotomy should not be considered as a generally desirable treatment for drug addiction per se, since it is not yet clear that the deficits consequent to frontal lobotomy are to be preferred to the problems associated with narcotic addiction.

In the withdrawal stage of treatment, psychotherapy is essential, for completion of drug withdrawal is usually associated with depressive reactions. During this period, addicted patients often become hostile, resist further treatment, and demand their release. Unless the physician is prepared to handle this situation, therapy may be disrupted and the patient may relapse promptly to the use of narcotic drugs.

Rehabilitation

In the rehabilitation stage of treatment, psychotherapy assumes the major role. Effective psychotherapy presupposes a thorough diagnostic appraisal of the individual. Therefore, adequate personnel and facilities for psychiatric and psychologic evaluation of patients are essential. While individual psychotherapy would seem to be most desirable, current limitations of adequately trained therapists make such treatment available to relatively few patients. At the Lexington Hospital an attempt has been made to meet this problem by providing a wholesome environment with adequate educational, recreational and occupational facilities (realistic farm, industrial and hospital work opportunities) for all patients, group therapy for a considerable number, and individual therapy for some patients with favorable prognosis. Evaluation of prognosis is based upon the age of the patient, the duration of addiction, the level of maturity he had attained prior to addiction, the degree of regression which occurred during addiction, and the presence or absence of chronic irremediable illness.

No rules can be prescribed for the psychotherapy of addicts, except that the therapist must realize that in addicts he is dealing with persons whose dynamic processes have been altered by their experience with narcotic drugs. Setting limits on the goals of therapy is essential for practical reasons. In general, the goal of therapy is to effect a substitution of more socially acceptable means of gratifying the needs of the individual for the use of drugs, rather than achieving complete maturity. The choice of therapy

through development of insight, corrective emotional experiences or conscious rational approaches depends on the training, experience and preference of the therapist.

In addition to formal psychotherapy, rehabilitation includes also correction of physical defects and provision for employment and follow-up treatment of the patient after his discharge from the institution. Unfortunately the latter has proved to be a most difficult problem. Because of this, appraisal of the results of treatment must be only tentative. On the basis of recent statistical studies at the Lexington Hospital, it was concluded that approximately 16 per cent of the patients treated at that institution remained abstinent from narcotics over a seven year period, and at least 20 per cent remained abstinent for extended periods of time. These figures are often regarded as disappointing, but actually the results of treatment are probably no worse than in many other chronic diseases such as diabetes mellitus or pulmonary tuberculosis. No stigma is attached to repeated admissions of such patients to hospitals for dietary and insulin regulation, or induction of pneumothorax. Yet moralistic censure prevails in society's views on drug addiction. It is hoped that, as a result of further dissemination of information regarding the true nature of narcotic addiction, a more rational public attitude to this illness will be engendered.

Addiction to Barbiturates

In the United States, addiction to barbiturates has been recognized as a clinical entity only since the experimental demonstration in 1949 that tolerance and well-defined abstinence changes develop quite consistently when these drugs are administered regularly and continuously in large amounts. The incidence of barbiturate addiction is unknown, but that it is relatively high is suggested by the fact that the annual production of these drugs in the United States amounts to over 300 tons. From both the physiologic and psychodynamic standpoints, little is known regarding the nature of the barbiturate addiction process. Many of the factors considered in relation to addiction to opiate-like drugs may apply to barbiturate addiction. However, in some ways barbiturates affect the organism differently than morphine. Their actions on the central nervous system are much more diffuse. Their disintegrating effects on repressive functions of the ego are much more marked than those of opiate-like drugs, while their depressive actions on conative functions are less, and appetite and sexual drives may be enhanced. In this respect, barbiturates are more similar to alcohol. Nevertheless, it is true that narcotic addicts often use large amounts of barbiturates and/or alcohol when their supplies of opiate-like drugs run low, though they do so only as a second choice.

DIAGNOSIS

Chronic barbiturate intoxication should be suspected in patients who are confused and irritable, react and speak slowly, exhibit somnolence, dysarthria, nystagmus or ataxia. The presence of round, punched out ulcers in the skin of the extremities may be due to subcutaneous injections of barbiturates, or attempts to inject them intravenously. Confirmatory evidence of chronic barbiturism may be offered by changes in the electroencephalogram. These are of two types; (1) a moderately high voltage mixed fast and slow diffuse dysrhythmia, and (2) diffuse slowing with dominant frequencies varying between 5 and 7.5 cycles per second. The former is more commonly observed. Chemical tests are available for the detection of barbiturates in the urine.

The clinical features of the syndrome which ensues on abrupt withdrawal of barbiturates vary in individuals and are probably related to the duration of addiction and the amounts of the drug to which the individual has been accustomed. In some, grand mal convulsions may appear suddenly between the 24th and 48th hours. In others, such seizures may be preceded by dyskinesias of various sorts, including tremors, choreiform and athetoid movements or bizarre involuntary movements of whole extremities, and these may occur without subsequent convulsions. Usually, such symptoms are preceded or accompanied by intense diffuse anxiety, perhaps also by impairment of the sensorium, and quite consistently by marked general weakness, fall in pulse pressure and elevation of blood non-protein nitrogen. The electroencephalogram usually is characterized by diffuse slowing and often by paroxysmal high voltage discharges such as are seen in patients with epilepsy. The electroencephalographic changes which occur in the barbiturate abstinence syndrome may occur in the absence of clinical seizures. When they occur, seizures are apt to recur several times and status epilepticus may supervene. Generally, however, they subside spontaneously after a day or two.

About the 4th to 7th day, further personality changes may occur in some individuals. The types of personality alterations which may be observed run the gamut of nosologic classifications. Anxiety states, homosexual panic reactions, paranoid reactions, hallucinatory-delusional states with clear sensorium, or delirium tremens-like syndromes with clouded sensorium, or amnestic-confabulatory states may be seen in different patients or in the same patient at different times. During such periods, the electroencephalogram may be slowed diffusely, or it may be within normal limits. If untreated, such personality reactions may persist from one to four weeks, but invariably subside, with few if any residua.

If barbiturate addiction is not suspected, a host of erroneous diagnoses

may be made, such as hysteria or other types of psychoneuroses, epilepsy, schizophrenia, alcoholic delirium tremens or Korsakoff psychosis. Anxiety states due to barbiturate withdrawal may not be recognized as such and a vicious cycle of futile attempts at psychotherapy, temporary sedation with barbiturates, renewed psychotherapeutic efforts and again replacement of barbiturates, may develop. However, a careful history and physical examination, with electroencephalograms and blood non-protein nitrogen determinations, should point to the correct diagnosis in a majority of cases.

TREATMENT

The treatment of barbiturate addiction is still in the stage of experimental investigation. If the diagnosis of chronic barbiturate intoxication is established, the drugs should be withdrawn slowly, perhaps over a period of a month. When the barbiturate abstinence syndrome has developed, replacement on barbiturates, in doses approximate to those to which the patient had been accustomed, will usually prevent convulsions or terminate them if they have already developed. However, the duration of psychotic reactions appears to be little affected by replacement on barbiturates. After the manifestations of the barbiturates abstinence syndrome have subsided, slow reduction of dosage should be continued over a period of about one month. At present, investigations on the possible use of cortisone in the treatment of the barbiturate abstinence syndrome are in progress at the Lexington Hospital. However, it is too early to evaluate the results of such therapy.

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PRESCRIBING A THERAPEUTIC PROGRAM

By KARL MENNINGER, M.D.

Editors' Note: The following article is the last half of the chapter "The Purposive Organization of the Case Material" from *A Manual for Psychiatric Case Study* prepared for use of Fellows in the Menninger School of Psychiatry. The first half of this chapter entitled "Diagnostic Analysis and Synthesis" was printed in the July 1951 issue of the *Bulletin*. The entire manual will be published in book form by Grune & Stratton in the fall of 1951.

The practical purpose of a diagnostic study is that of scientifically planning a treatment program for a particular patient.

Having collected the historical and examinational data, and having organized it diagnostically, *i.e.* meaningfully, the physician seeks to take advantage of every bit of modifiability or reversibility implicit in the situation. He will bear in mind that the phenomena of illness are the patient's reactive, attempted solution to an overtaxing of his adjustment capacities stimulated by reality (environment) factors. The doctor must consider what can be done to change the environment, *i.e.* those features of the environment which the patient cannot deal with successfully, and what can be done to change the patient so that he can deal with this or some other environment better. This might be called fundamental treatment. In addition, the physician is always obliged to render some first aid treatment which is essentially an attack on certain symptoms. This must be done cautiously, remembering that symptoms exist for a purpose—even though they have the tendency to overdo their function and add secondary pain and trouble to the patient's burden.

Thus there is an immediate aim of treatment related to life-saving, and pain-saving, and there is an ultimate aim relating to the promotion of a more comfortable and less expensive life adaptation. For example, the immediate aim of treatment in a case may be to prevent suicide by special vigilance, and to relieve insomnia by a sedative; the ultimate aim may be to restructure a marital relationship which has been unendurable for both parties and to which the patient has reacted by the depression and insomnia *and* other symptoms. This may mean helping the patient to achieve a more mature attitude toward his wife, and it may mean, also, some special efforts to help her to be a better wife.

Programs of treatment can therefore be organized according to their *immediacy*, according to their *object* (patient and environment), and according to the empirical usefulness of selected, available, established *modalities*. They can also be organized according to the chronological order of procedure.

The first practical decision a psychiatrist has to make is whether or not

he is to accept the patient for care beyond the immediate hour or week during which he makes his examination. If he decides not to accept the patient for (further) treatment, it is his responsibility to direct him somewhere else—either back to the referring physician or, with the referring physician's concurrence, to another physician, to a social agency, or to his (the patient's) own home. Under these circumstances the psychiatrist passes the responsibility for the patient to someone else, and with that passing of responsibility goes a certain obligation to report his opinion and his suggestions in regard to changes in the environment or in the patient's life program derived from his study.

Such rejection, dismissal, or transfer of a patient constitutes essentially an abortive type of treatment. Most psychiatric treatment programs are based on a continuance of the physician's relationship with the patient, either in ambulatory or out-patient status or in hospitalized status. Hospitalization represents not only a more radical change in the environment, but a more concentrated and elaborate therapeutic effort. It is much more expensive, which is one good reason for avoiding it if possible. It assumes and indeed enforces a much higher degree of passivity on the part of the patient, which in psychiatric illness is also less desirable, except temporarily. It has to be supplemented, usually, by subsequent out-patient treatment, and hence the patient who can begin in out-patient status immediately, even though he be dislocated from his normal living habitat, has a considerable advantage in time.

In spite of all this, however, there are many cases which must be hospitalized for one or many reasons. Chief among these reasons are the necessity to prevent the patient from injuring or destroying himself, the need to expose the patient to a radical change of environment of a selected type, the need to protect the patient from misunderstanding and mishandling by the environment, and the desirability of certain treatments that can be efficiently and safely done only in a hospital. Hospital treatment is full time treatment; out-patient treatment at best can be only part time, not only with respect to the time of actual exposure to therapeutic agents, but also the preoccupation of the patient and engagement of his interest and activities.

Treatment in Out-Patient Status

Let us assume first that the psychiatrist has decided to permit the patient to remain in *out-patient status*. The psychiatrist should be prepared to answer the following questions:

1. Where will the patient live?
2. How much and what kind of supervision or companionship is it necessary to prescribe or arrange? (relatives, friends, volunteer companion, assigned companion or psychiatric social worker)
3. What machinery exists for counselling or directing this supervision?

4. Where, when, how often and for how long will the psychiatrist see the patient?
5. In these patient-psychiatrist sessions, what type of therapy will be employed?
6. What symptomatic therapy for immediate relief is to be prescribed? (for example, sedation)
7. What general modifications in the patient's mode of living are indicated from the diagnostic study?
8. What arrangements need to be made for additional medical, surgical, and even psychiatric consultations?

These questions do not cover all contingencies, but represent a minimal range of programing which should be fairly definite in the psychiatrist's mind at the time he sees his patient for the first interview following the completion of the diagnostic studies. He should remember that the patient has been eagerly, apprehensively, hopefully awaiting this appointment. When it comes, he should be put at ease—unless complacency is one of his symptoms. He should be told what is *not* wrong, what *is* wrong, and what can be done to right that wrong. The rationale of the physician's decision need not be given in detail, but the function of the psychiatrist and the responsibility of the patient in the proposed scheme of therapeutic management must be defined. It should be defined clearly, definitely, and optimistically. Many physicians make the error of trying to preserve scrupulous scientific verbal accuracy at the expense of leaving the patient still frightened, still uncertain, still hopeless. No honest physician will say anything which he doesn't believe to be true, but it is cowardly to hedge and qualify and evade in order to preserve an ideal of impeccable accuracy for narcissistic reasons. If a physician doesn't believe he can help a patient he ought to say so, and transfer the patient to someone who can. But if the physician does believe he can help the patient he ought to say so, and say so definitely. Nothing in the world is accomplished without optimism, and the fact that optimism may be philosophical or temperamental, and hence not entirely rational, should not disqualify it. The physician himself in all his wisdom may not know exactly why he believes he can help the patient, and indeed he may be mistaken, but if he does believe it and shares that belief with the patient he has already taken a step toward realizing it.

Treatment in Hospitalized Status

What has just been said in the last paragraph applies equally in case the patient is to be hospitalized. However, in hospitalization much more of the responsibility for the treatment of the patient is assumed by the physician and the hospital. This is both feared and desired by patients, and in most instances the fear is greater than the desire. Hence the first step in hospitalization therapy is to deal with the patient's misgivings and reluctance

with respect to the surrender of his freedom to go and come and to order his life as he chooses, even though he realizes that his choices have been regularly unwise. Much of the patient's fear is based upon misapprehension and misconceptions about psychiatric hospitals. To be sure, these fears tend to diminish after a while, even in cases where the patient must be involuntarily detained or confined. But this is to learn the hard way. Modern psychiatric thinking is all in the direction of encouraging as much as possible the voluntary admission of psychiatric patients. This is not always possible, but it is possible in many more cases than we used to think, particularly in view of the general improvement in psychiatric hospital treatment and reputation. It is the psychiatrist's responsibility to further voluntary admission as much as possible; I see no reason why the psychiatric patient should not enter a hospital for treatment if and when and because he wants to, without further formalities than his request and his physician's endorsement, just as does any medical or surgical patient. It may not be feasible for him to leave the hospital whenever he chooses, and for this reason special legal authorization must be granted those in charge of psychiatric hospitals for detention if necessary. (See the proposed psychiatric hospital admission law prepared after long study by the Kansas Psychiatric Society included in the Appendix. A somewhat similar model law has been prepared by the United States Public Health Service.) The psychiatrist should never make the mistake of promising what cannot be promised, of denying the existence of detention or of minimizing certain practical difficulties such as the necessity of removing razors, knives, scissors, and matches from all patients. He should explain on general principles why these things are done and indicate the general purposes of the hospital program.

The next step in hospital therapy is the arrangement of a proper reception of the patient by the nurses and aides and other patients on the ward where the patient is assigned. The patient should be seen immediately by the nurse, introduced to the aides, introduced to some of the other patients, and in general reassured with respect to the friendliness and good will of the institution. If the morale and team organization is what it should be, there will be an increasing "build up" for the other employees and for the advocacy of the hospital as a whole resulting from each contact. Nurses will speak highly of aides, aides will speak proudly of physicians, physicians will commend therapists and so forth. The patient should be visited shortly after his admission by the psychiatrist himself, to re-establish and confirm a contact begun outside the hospital and to be reassured regarding new alarms. If the psychiatrist in charge is a different one, a new relationship has to be established which will become increasingly important.

An explanation of all the rules, regulations, privileges and possibilities of the hospital should certainly be deferred for a few hours or a few days. Plenty of new sights and sounds are reaching the patient's eyes and ears

without his having to be confused by a lot of instructions regarding curfew hour, cash withdrawal and passes. It is enough if he is told who some of the people about him are, and where the toilet is (on the first day).

After the acclimatization of the patient, the next step in hospital treatment is to explain to the patient (again, perhaps) what the program of treatment is to be, what it hopes to accomplish, who will help in its administration, and what the patient's part in the treatment is. The program will certainly contain some details which do not need to be explained to the patient, but they should all be clearly in the physician's mind and he should be sure that they are, similarly, clearly in the minds of the therapeutic team, *i.e.* the nurses, the aides, the therapists and the social workers.

The previous paragraph assumes that the patient has been examined before his admission to the hospital. Very frequently—perhaps in most instances—this is not the case. Obviously, then, before a treatment program can be designed for the patient and explained to him, (beyond the basic hospitalization routines) the examinations outlined in the previous pages must be completed. In a sense these examinations themselves constitute the beginning of treatment, and often they are very effective treatment, indeed. But not all of the patient's time nor all of the physician's time will be taken up in the examinations, and the spare time of the patient, so to speak, requires planning and cushioning. There ought to be a minimum of long, weary, anxious, painful hours (for the patient) relieved only by his anticipation of the physician's return. The complete treatment program may have to be introduced in parts and pieces, tentatively, as fast as definite indications are detected. Naturally, like all treatment programs, it will be subject to revision in the light of further knowledge.

The following outline is a skeleton for a prescribed program:

1. Program of admission, introduction, orientation, etc. (This may be routinized, but the specific responsibilities should be known and special requirements anticipated. See preceding text.)

2. Treatment by the Psychiatric Team, specifically prescribed by the physician and carried out by physicians, nurses, therapists, aides and social workers.

    a) Medical and Surgical Therapy

        (1) Sedatives, vitamins, other pharmaceuticals
        (2) Dietary and other hygienics
        (3) Psychotherapy; type, frequency, etc.
        (4) Special procedures (dental, surgical, insulin, electroshock)

    b) General Nursing Management

        (1) Special nursing orders and precautions
        (2) Responsibilities (privileges) to be granted or withheld, and special precautions to be taken

(3) Ward work assignments and responsibilities—what, when, how much
(4) Attitudes (see below)

c) Attitude Therapy

(1) General attitudes to be taken by all toward patient
(2) Special attitudes regarding specific types of problems

d) Physical Medicine Rehabilitation Therapy

(1) Physical therapy (electric, orthopedic, massage, hydrotherapy)
(2) Occupational therapy
(3) Educational therapy
(4) Creative arts therapy
(5) Bibliotherapy
(6) Manual arts therapy
(7) Recreational therapy
(8) Active sports program
(9) Group therapy (discussion groups, drama therapy, etc.)
(10) Vocational counselling and testing
(11) Off ward project work
(12) Social activities

e) Contact Functions (usually handled by the social worker)

(1) Arrangements regarding outside responsibilities, needs, business affairs, etc.
(2) Counsel to relatives *in re* reports, letters, visits, attitudes, desirable changes, etc.

Incidental to hospitalization and the inauguration of a treatment program there are certain administrative responsibilities which the psychiatrist should undertake. Chief among these are the following:

1. The writing of an admission note on the patient's chart immediately after the patient has entered the hospital and has been seen by the physician. Such an admission note not only serves as an original record which in subsequent emergencies is of the utmost legal and scientific importance, but it serves to orient the nurses and aides and medical consultants as to the general nature of the case. The minimum contents of the admission note should be:

a) The patient's residence, responsible relative and religious preference
b) The general nature of the patient's illness as determined from pre-hospital examinations
c) Special problems of the illness—for example, suicidal or convulsive tendencies—which should be known to *all* hospital workers
d) Comments on the patient as seen in the first hospital interview by the psychiatrist, including, for example, the patient's first

reactions to hospitalization, and requests or complaints likely to be repeated to the nurses

e) A brief statement of the general physical condition and medical status

If there are specific attitudes or techniques of management which should be known to others than the nurses, for example, visiting consultants—these may be appended to the admission note because the orders (see below) will usually be transmitted directly to the nurses and may elude the attention of other professional visitors.

2. An initial tentative order sheet for the nurses and for the adjunctive therapists should accompany or precede the patient to the ward. It will be replaced with more complete and definite orders, based on the above outline, within 24 to 48 hours, and this in turn will be revised and amended as the case proceeds.

3. Authorizations for certain types of examinations, for certain types of treatment and for release of information about the patient must be obtained from the responsible relatives. Requests for these should be instituted promptly, as soon as a decision has been made regarding the likelihood that such procedures will be necessary.

4. Periodic review of the treatment program with appropriate revisions in the management devices and attitudes as indicated by the patient's response or lack of response. This involves a full explanation to the nurses and therapists on the one hand and frequently to the relatives on the other hand, particularly if external reality situations are involved. To enable her to assist in the latter, the social worker must also be briefed.

5. Notes on the progress of the patient.

Post-Hospital Treatment

It would be improper to conclude a discussion of hospital treatment without some reference to the continuation of his treatment which will presumably follow his dismissal from the hospital. In a sense, treatment in hospital status is only a prelude to treatment in out-patient status, or in what has recently been called day-hospital status. The planning for this will begin long before the patient leaves the hospital, and will be discussed with the patient shortly before he leaves the hospital.

Whether the patient is transferred to day-hospital status, to out-patient status, or to home-treatment status, plans should be made for the following:

1. Living arrangements—where? with whom?
2. Continued treatment—type? with whom?
3. Vocational changes—when and if necessary
4. Recreational program
5. Schooling—where? when? what? etc.
6. Education of the relatives most concerned
7. Return visits to physician—regular or occasional ("check-ups")

Upon the occasion of discharging the patient from the hospital or transferring him to some other part of the hospital, the psychiatrist will complete the progress notes and write the discharge note summarizing treatment given, the patient's present status and so forth. In our hospital a transfer from the hospital to out-patient status requires the filling in of a form summarizing some of these points.

Research Implications

In the thorough study of every case the alert physician encounters paradoxes, internal contradictions, unexplained phenomena, and unique constellations. There always remain unsolved problems, and there always exist challenges to further investigation of special and general aspects of a case. New data is derivable from every patient studied which indicate support, modification or even refutation of some of our hypotheses.

Every thoughtful physician is faced with the temptation to continue study of a particular case far beyond practical necessities. But the temptation also exists to adopt the habit of ignoring the research implications either in general or in particular because of "lack of time" and other such excuses.

One is obliged to steer a discriminating and perhaps a somewhat vacillating course between Scylla and Charybdis. At the conclusion of the study of every patient it is a good thing to set down a list of the unanswered questions. Some of these need not remain unanswered indefinitely; further historical or clinical investigation can be instituted which will answer them. Consultants may be useful when, for example, the fields of high specialization are involved, and when the examiner feels the need of a more detailed or perhaps more experienced observer. Continued observation of the patient will often answer some of these questions, but some will always remain forever unanswered.

It is a good intellectual exercise to list the unique features of each case. Ask yourself: Why is this case especially interesting to me? What does the case particularly well illustrate? If I should write an article on this some day, what books have I consulted which threw light on particular problems or features of this case?

Questions such as this keep alert the scientific spirit and attitude which must never be lost in the course of routine clinical investigations.

PSYCHOLOGICAL TEST REPORTING: AN EXPERIMENT IN COMMUNICATION

By HELEN D. SARGENT, Ph.D.*

Communication between the psychologist who examines a patient and other members of the psychiatric team who treat him is an important interprofessional problem. The psychological test report is the main (though not the only) purveyor of information to others. Those who are professionally charged with responsibility for a patient refer him for testing because they look to the psychologist to make a unique and illuminating contribution to needed understanding. The question of what a test report should communicate, and in what fashion, is a much discussed subject among both the writers and the consumers of test interpretations, but has not been answered to the full satisfaction of either.

The reports below have been written for the purpose of comparing different methods of reporting. In them an effort has been made to convey essentially the same information about a patient in four different ways, varied according to purpose, nature of questions to be answered, and technique of communicating. Each of the four reports will be preceded by a statement of purpose and technique. In conclusion a comparison of the methods will be made, and some questions raised.

All four reports are concerned with a single patient referred for a differential diagnosis between an acute anxiety state and incipient schizophrenia, and for a description of "what is going on" in the patient. All reports were composed by the same psychologist on the basis of one test only, the Sargent Insight Test.† None are offered as examples of a "best" of kind; neither are the four varieties regarded as exhaustive. The nature of the referral problem, the object of testing, the background of the persons for whom a report is written (and even their personal preferences) should largely determine the kind of report submitted. Unfortunately, in practice, these determinants are occasionally disregarded, resulting in confusion and sometimes in mutual dissatisfaction.

The main conclusions of the psychologist, elaborated in different ways below, are, in brief, as follows: (1) The patient is an individual who has in the past handled his feelings (especially hostility) by evasion or by acting

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† A full battery had been administered by another psychologist but in order to avoid inter-report variations due to the greater adaptability of material from certain tests to one or another style of report, the Insight Test (which had been interpreted by the writer) was chosen as the base.

impulsively. (2) He still clings to these methods but is now losing control over thought and behavior. (3) He is greatly frightened and wants help, yet at the same time tries to hide and deny this need. (4) Although he has probably already experienced hallucinations, he has not lost contact with reality. (5) A more acute phase of psychosis is imminent.

The reader is asked to endure an inevitable repetition of this theme and to compare the four reports in terms of (1) usefulness for understanding the patient; (2) completeness and coherence of description; and (3) logical relevance of material included. He is asked, also, to contrast them on any other variables which seem to him important. Possibly certain features of all four reports should be combined. Maybe the variations add little to the skeleton summary above. Perhaps an entirely different departure should be made. The sole purpose of the experiment is to involve the reader in a discussion of method for the sake of improvement, rather than to defend any or all of the methods tried.

Report I

Purpose: To describe the patient as a living person in a way which makes possible an understanding of his experience, *from his viewpoint.*

Technique: Non-technical language is used to (1) describe attitudes and behavior which, on the basis of the tests, appear to have been characteristic of the patient; (2) portray his current subjective experience including the threats he fears and his efforts to meet them; (3) evaluate the psychological danger confronting him and the effectiveness of his means of coping with it; (4) provide suggestions as to how he might be helped and (5) estimate the therapeutic prospect. On the assumption that the test behavior sample furnishes a reasonably valid basis for inferring answers to the above questions, and that some users of the report will be untrained in the technical interpretation of raw test data, descriptions of performance are cited for illustrative purposes only.

The Insight test responses for this patient describe a man who has never found it easy to live with his own emotions. In situations which tend to stir them, his habit is to put the matter out of mind, to make light of his feelings or, if this proves unsuccessful, to carry out the first act that occurs to him in order to relieve his discomfort. His relations with other people have probably been unsatisfactory to himself and to them because his impulsiveness makes trouble. He tries to win favor and maintain self-respect by assuming approved social attitudes, but there is more hate than liking for others in his inner feeling. A problem which concerns him is the question of whether he is a real man. If he does not assert himself, he feels weak, vulnerable and frustrated. If he does, the underlying feelings of anger and resentment get out of hand. He needs someone like the "submissive type girl" he mentions on the test in order to feel safe in acting aggressively.

At the present time he is experiencing terrifying changes within himself.

There is an upsurge of rage which he feels unable to control. At times, in spite of effort to deny fear, he is so frightened that he is unable to think; at other times he undergoes peculiar experiences; alien thoughts and perhaps voices which express themselves in a threatening or compelling way. For example, on the test he wrote (in the midst of an otherwise more intelligible series of responses) "BORIS TRANS MAGNIFICATION DAMNALITY."

Despite his fear, confusion, and desperate need to ask help, he still keeps up a pretense which apparently served him in the past: adopting a joking, cynical attitude to hide his problem from others and to play down his own anxiety. By this device he has so far managed to hold himself together; that is, in most situations he can cover up. Fluctuations in this control are, however, seen in the test performance. At the outset he writes fairly adequate answers, but these are soon interrupted by a sudden refusal to comment which carries through several questions. Recovery takes place by means of flippant answers following this block. References to feeling, which the test normally elicits, are almost entirely omitted until the last third of the test and are then accompanied by increasingly peculiar statements which represent disordered thinking. On an item in which "jealousy" is usually mentioned, he substitutes "felt squishie." A crescendo of aggressive expression (at first subtle) leads toward the end of the test to an answer expressing intense anger, preceded and followed by references to "making an ass of himself" and to "confused and conflicting life." In conclusion he recovers again the joking, facetious note and ends the paper with "How Now Brown Cow. Tune in again next week, same time, same place" etc.

Complete loss of touch with the real world and an actual outbreak of violence are not unlikely. The patient will be difficult to help because of his great fear, his habit of running away, and the distance he habitually keeps between himself and others. However, he is struggling against, rather than surrendering to the inner disturbance and is acutely aware of a need for help. A firm, supporting approach which takes care not to rouse fear might succeed in taking him through his present emergency. The prospect for leading him to a more thorough-going revision of his adaptive habits is less favorable.

Report II

Purpose: To describe the degree and kind of abnormal psychological functioning in the patient, and to consider this within the context of a systematic theory of personality. The aim is to conceptualize mental disorder in such a way that dynamically similar individuals may be differentiated from others and hence treated in accord with the clinical experience accumulated with reference to a given syndrome. Uniqueness and differences between individuals are noted but within the framework of categories derived from theoretical psychodynamics.

Technique: Terms which have technical meaning within dynamic personality theory (psychoanalysis and its derivative ego psychology) are used on the assumption that the report consumer is acquainted with these constructs, and that their application to an individual case is an aid to organizing a view of the specific ways in which a dynamic process has become pathological in a given patient. The technical terms and concepts are, furthermore, considered to be more economical and cogent carriers of meaning in this context than if they were to be translated into everyday language (*cf.* REPORT I). The technical vocabulary is designed to describe such aspects of ego structure as (1) preferred defense mechanisms and modes of handling impulse arousal, (2) affective and intellectual resources and reserves, (3) manner of thought functioning and the degree of preservation, disruption, or deterioration of thinking and concept formation, and (4) basic dynamic conflicts assumed to be at the root of disorganization.

The tests present evidence of the presence of a schizophrenic process, manifested by intensification of aggression, beginning thought disorder, and panic. This process is encroaching upon a narcissistic character structure in which denial and avoidance (preferred modes of defense) are breaking down. An ingratiating front has thinly concealed shallowness of affect, immaturity, weak object cathexis, and an underlying hostility which the patient is unable to control when affective concomitants of impulse penetrate consciousness. Unable to tolerate anxiety, he acts out impulsively when evasion fails. Basic conflict centers about inadequacy in the masculine role on the one hand and fear of the consequences of aggression on the other. For example, he refers first to the need for a "submissive type girl in order that he might fulfill his role as a masculine, aggressive homosapiem (sic)," and then, in the next response, describes a man who "had character and a friendly understanding nature and did what was first promised. . . ." Later in the test he substitutes a semi-neologistic word for "jealousy" and finally gives way to an aggressive statement, bizarre in form and psychotic in proportions: "He told his nosey friend to hold his tongue or he would smear alum on his larynx."

Flight from affect with intermittent control breakdown follows a cyclical course on the test which reflects the precarious process by which this patient is attempting to stem the drives which threaten to loosen the grip on reality. Good contact and adherence to instructions is, for example, apparent in the first three items. These are followed by caution and blocking in a series of responses which ward off all affective meanings of the stimulus. Subsequently there is intermittent partial recovery by recourse to denial. An undercurrent of hostility culminates in an absurd and confused response (unrelated to the question) which reads: "The man obviously had gaul-bladder (sic) trouble in which case he should consult his dog." When the denied affect finally breaks through in a response beginning "The man felt

disturbed and tried to commit—" this is followed at once by dramatic disruption of thinking with primary process emergence in neologistic form: "BORIS TRANS MAGNIFICATION DAMNALITY." The cycle is resumed by another effort at avoidance, by expression of insecurity, outburst of aggression, and finally by a statement of despair, confusion and need for help. The protocol ends at last on a note of denial masquerading as a witticism.

A frank psychotic break with loss of reality contact, paranoid features, and outbursts of violence are possible in this individual unless extreme tension can be mitigated. Prognosis is poor, in view of the premorbid absence of integrative control over affects, the poverty of interpersonal rapport, and the present acute panic state which will render any approach which touches upon his difficulties likely to set off the flight reaction. At the same time, the struggle which the patient is making to maintain contact, his obvious cry for help, and the resistance to disorganization which is evident in the remaining defense, suggest some degree of ego strength which might be utilized and enhanced through supportive therapy.

Report III

Purpose: To arrive at hypotheses concerning the patient's condition which, if confirmed by other interpreters and verified by additional evidence, may be used as a tentative basis for treatment.

Technique: On the assumption that psychological testing is primarily a research procedure which has not reached the degree of precision which warrants drawing only one set of conclusions from a given set of data, relevant raw material is included systematically in connection with each inference drawn in order that readers may judge the inferences for themselves, deriving additional hypotheses independently. The method of observation used and the circumstances of testing are also described for the same purpose. No effort is made to provide a complete and integrated picture of the patient, but rather to draw only those conclusions which the data themselves appear to support clearly.

Tentative hypotheses concerning this patient's condition are presented below, together with evidence from the Insight Test which supports them. The interpreter did not see the patient, is unfamiliar with his history, and knew only a few salient facts of his clinical problem. The Insight Test is a verbal projective technique which is interpreted qualitatively according to the same principles used in the analysis of other verbal materials. Norms are also available for the quantitative scoring of certain formal characteristics of the protocols which, according to preliminary standardization, differentiate certain nosological groups. In evaluating the conclusions drawn, the limitations imposed by the use of one test only (an instrument still in the process of validation), should be recognized.

1. Psychosis, in incipient form, is present in this patient.

Both the affect score and the *A/E quotient* (ratio of feeling expressions to ego defense expressions which elaborate, evaluate and/or qualify content) are below the mean for psychotics and very low for normal subjects. *Malignancy indicators* including lapse into the first person pronoun (interpreted on this test as ego boundary weakness) are present. *El* and *Ev* scores are excessive, predominating over *Q* which is normally most frequent.

Blocking and refusal to meet the terms of the question occur in a series of two and a half consecutive items without apparent relation to stimulus content. Production in the majority of questions is constricted and at times irrelevant.

One intense aggressive expression occurs in the latter portion of the test, in response to an item which asks what a husband who is "told by a friend that his wife has callers in his absence" would do and feel: "He told his nosey friend to hold his tongue or he would smear alum on his larynx."

Several peculiar, inappropriate and neologistic expressions appear. For example: "The man obviously had gaul-bladder (sic) trouble and therefore should consult his dog." Subsequently the following is written: "The man felt disturbed and tried to commit BORIS TRANS MAGNIFICATION DAMNALITY."

2. The patient feels frightened and inadequate and is conscious of his need for help.

In a response following the neologistic phrase quoted above, he writes the answer: "Probably made a complete ass of himself." His last answer reads: "He did not know what to do that's why he asked the doc, he was confused and frustrated in his conflicting life."

3. The patient's means of handling affect is by avoidance and denial.

When, presumably, the task begins to disturb him (as after the first three adequate replies) the blocking noted above occurs: "I would have to know more details about this problem before I could weigh any decision one way or the other."

After recovery from this block, the patient resorts to a joking approach in responses such as: "He got married and gave his mother back to the Indians. . . . He quit work and joined the chain gang. . . . He told his friend to get his face lifted . . . That's the way it goes old bean." Even in the aggressive expression quoted in 1, above, it is worth noting that the anger is accompanied by denial in the form of a demand that the friend not tell him something which will disturb him.

4. The patient still clings to these avoidant defenses in spite of their inadequacy.

After the reference to confusion and "conflicting life" the patient ends facetiously with "How Now Brown Cow, Tune in next week same time, same place, to hear another in the series of—Reynard Fox Captures Brer Rabbit."

The humorous, subtly hostile method of avoiding the question follows the first block and precedes and follows the outbreaks of confusion and aggression.

5. The patient is not out of contact and is still able to maintain a front by means of which he strives to hide his growing panic.

This hypothesis is based upon the sequential arrangement of responses described above. The final note of mockery may, of course, be regarded as representing the last stage of nihilism at which nothing is important, or as a last effort to remain "normal" by treating threatening emotions as jokes.

6. Further breakdown should be anticipated in the form of more manifestations of thought disturbance and perhaps by a violent outbreak of aggression.

Extreme tension is shown by the flight from affect and the fact that when it comes through (in the first spontaneous reference to a feeling state which is delayed until item 11) the phrase "he felt disturbed" is followed by lapse into neologistic wording. When precariously maintained control of affect breaks, psychotic disorganization results and reality is lost. It may be inferred, therefore, that the same pattern will appear in behavior.

7. The success of psychotherapy is problematic.

This conclusion is based upon the extreme fear and tendency to flight reaction noted above.

Report IV

Purpose: To describe the patient as a total individual and to estimate the degree and kind of pathology encroaching upon the normal (or premorbid) personality. The report seeks to describe impairment in such areas as perception, intellection, emotion and action, to assess the effectiveness of integrative and adjustive processes, and to evaluate the test data from the standpoint of diagnostic classification and prognosis.

Technique: Observations are presented by a systematic classification of inferences and data according to the Menninger Psychological Examination outline. This outline provides for a many-sided description of the present functioning of part and integrative processes, and organizes the material in convenient form for cross comparison between inferences drawn from various orders of data (*e.g.* psychological tests, interviews, ward observations, etc.).

A. GROSS IDENTIFICATION

The patient was referred to a psychologist (other than the writer) on the Appraisal Service of a Veterans Hospital. This report is based on analysis of the Insight Test only, without direct contact by the test interpreter with the patient, and without examination of history and other test data.*

* In routine test reporting, "Gross Identification" would include identifying data on age, occupation, general appearance, and presenting symptoms described if possible in the patient's own words. The writer did not see the patient and had available only the information that a question of differential diagnosis between anxiety state and schizophrenia had arisen. Additional data regarding the patient is, therefore, not included here since the purpose of this paper is not to examine the validity of the test or its interpretation but to compare methods of reporting. It is of interest, in view of the findings, that this man left the hospital against medical advice a few days after the initial tests and interviews, confirming the strong impression of fear and denial which the test results suggest.

B. PART PROCESSES

1. *Perception*

Although the patient is not out of contact, as shown by the fact that he can read and respond to some of the questions according to instructions, interference in the apprehension of reality occurs in the form of inappropriate interpretations and several bizarre and disorganized verbalizations. It appears that the stimulus items are perceived and responded to in a highly personal way, in terms of the patient's own needs and fears, a fact which suggests that the patient distorts objective reality according to his own needs. For example, *elaboration* (introduced content) is scored in one response because he writes: "The children obviously lived at home," whereas in the stimulus item no children are mentioned.

2. *Intellection*

Normal intelligence may be inferred from the patient's use of language which, although misspellings and queer expressions occur, appears at about the level of a high school education. For example, he tries for the term homosapiens ("homosapiem"), and uses words and phrases such as frustration, conflict, aggression, "fulfill his role," etc. Thought processes are, however, seriously disrupted. Distortions and neologistic expressions intrude in the protocol, as in the expression written in capitals "BORIS TRANS MAGNIFICATION DAMNALITY." Thought content is constricted in expression as evidenced by brief, and at times irrelevant, answers. A possible conscious preoccupation and basic source of conflict is concern about the masculine role as expressed in the preference for "a submissive type girl in order that he might fulfill his role as a masculine, aggressive homosapiem (sic)."

3. *Emotion*

The patient's frequent failure to respond to the test instructions which require an answer to the question "How did he feel?" suggests habitual avoidance or repression of affect (*A* score far below normal mean). Blandness is eliminated by the fact that affect eventually breaks through in violent form. No direct, spontaneous expression of feeling occurs until Armature 11 in which the character is described as "disturbed." The fact that this statement is followed at once by the bizarre phrase quoted in B., 2. (see above) indicates that affect is not absent, but constricted, and that when it comes to expression, disorganization results. High tension and severe emotional disturbance are suggested by this relative absence of feeling expression (except in isolated and exaggerated form) and by the constant introduction of flippant, facetious responses covering an under-

lying hostility which finally emerges in an angry outburst: "He told his nosey friend that he'd better hold his tongue or he would smear alum on his larynx." These qualitative observations are borne out by results of formal scoring which ranks the patient (on the A/E quotient) far below the psychotic mean in spontaneity and in flexibility of emotional control.

4. *Action*

Nearly half of the expressions scorable as "feeling" occur in action words. According to the interpretation of the Insight Test, this result indicates a high degree of impulsivity and a tendency to discharge emotion in action with little regulation or regard for consequences.

C. INTEGRATIVE PROCESSES

1. *Relation to self*

The role which this man wants to play is that of a wise-cracking good fellow who does not take things too seriously, and who retaliates only in a joking way when threatened or injured. For example, his hero tells a rival "to get his face lifted." He would like to see himself as "masculine and aggressive" and at the same time as "friendly and understanding." His present inability to live up to either an aggressive or a passive role is a part of the breakdown which now threatens. Like heroes about whom he writes in the test, he "feels disturbed," "makes a complete ass of himself," and is "frustrated in his conflicting life."

2. *Relations to others*

Relations to others are essentially distant and are attempted through compliance which gives way to hostility when the interpersonal situation becomes threatening. In question 2, a "man of character and friendly understanding" is described, but more and more open anger and resentment are elicited as the protocol continues. (See B. above.)

3. *Relation to things* (sublimation)

No evidence on Insight Test.

D. REACTIONS TO DISINTEGRATIVE THREAT

1. *Normal reactions*

An effort to utilize the normal tension relieving device of humor is seen in several flippant answers ("That's the way it goes old bean," etc.) and in the conclusion of the response record on which he writes "How Now Brown Cow. Tune in next week, same time, same place," etc.

2. *Emergency reactions*

Relief by ordinary means cannot be maintained without the first order defense of hyper-suppression, and various second order defenses including avoidance, denial and the beginnings of projection. Ego rupture appears imminent in view of the test representatives of confusion, violence, and excitement. Formal scores such as the low A/D quotient, low absolute Affect level, and the presence of malignancy signs support the view that defense structure is crumbling.

3. *Aspects of present disequilibration*

The tests suggest that the sequency of psychological process is leading from long standing character disorder into the early stage of acute psychosis. Intense anxiety feeling is experienced but is hidden behind a facade which the patient uses to protect himself from others, and to reassure himself. The capacity for insight appears to be very limited in view of the tendency to deny and project.

E. DIAGNOSTIC SUMMARY

The principle features of the above findings are high tension, the breakdown of defense, and the development of thought disorder. Although surrender to disorganization has not taken place, an active pathological process is clearly reflected in the test protocol. These findings are consistent with a diagnosis of incipient schizophrenia going into the acute stage, which is likely to show paranoid features. The character structure of the individual, in whom there has been heavy reliance on premorbid defenses of avoidance and denial, poor control of impulse, distant interpersonal relations, and inadequacy in the masculine role, suggests that treatment may instigate the habitual flight reaction. On the other hand, some degree of ego preservation is present which might be enhanced through supportive therapy.

Summary Comparison

The four reports differ in purpose, vantage point, and logical orientation. Reports I and III are, for example, primarily descriptive rather than diagnostic in purpose. Both aim to portray something about the patient, his way of living, his condition, or his functioning on the test. Although personality description lends itself to diagnosis and prognosis, there is less emphasis in Reports I and III upon the categorical end-product of description, the diagnosis itself. In Reports II and IV description occurs but is geared to the final synthesis and its implications, expressed in a nosological generalization.

In all except Report I the vantage point is the observer's, not the patient's. The situation as the patient experiences it (as inferred from the test data) rather than its dynamics or its etiology are presented in Report I. This approach which is essentially phenomenological (insofar as it seeks to understand how the patient feels the problem) introduces another difference between the first and last three reports. Value terms from the observer's frame of reference (such as "egocentric," "shallow," "immature," etc.) are almost wholly absent from Report I but occur conspicuously in the other three.

The term *logical orientation*, mentioned above as another dimension of difference among the reports, is used to subsume not only differences between empiricism and rationalism but distinctions in relative reliance upon constructs from a theory of personality. Although theory (which necessarily exerts an effect upon the way in which the interpreter perceives and organizes), is implicit even in the impressionistic description of Report I, no attempt was made there to order inference with reference to theoretical formulations as in Reports II and IV. Report III, on the other hand, is empirical, emphasizing the source of all inductions, and setting forth only those generalizations which can be documented. Report IV embraces most comprehensively both the inductive and deductive report methods and seeks to combine empirical-analytic and hypothetical-synthetic logic.

It is also worth noting that none of the reports (written on the basis of one test alone without supplementary clinical observation) actually describes the individual in a way which would make him recognizable among others except on close acquaintance. Certain statements are made as to how such a person might behave and what, in general may befall him, but the bulk of all four reports deals essentially with *internal* aspects of the person which may or may not be manifest. This raises a fundamental issue regarding the value of test findings: should they be asked to describe a person in a way to correspond with what may be apparent by other means, or is there greater value in explaining, or at least in conceptualizing, what presumably lies beneath the observable? Reports of the type which deal with internal affairs, by reason of the universal nature of the states, needs and problems described, give an impression of generality rather than individuality to the reader who is not acquainted with the patient. Yet the same report may bring consistency and meaningfulness to the understanding of those who have been in contact with him puzzling, perhaps, over manners and actions which in themselves may not offer clues to their source.

Among the questions which might be raised by the reports are the following: Is a psychological test itself a research procedure subject to the methods and conventions of research, or is it an application of valid knowledge gained by research and experience? Is theory a means for interpreting

individual test results, or is the individual interpretive study occasionally used as an exercise in the illustration of theory? What is the role of value, social or personal, in the description of a patient? What is the purpose of a psychological test report? Do we who write them share the purposes of those who read them? If not, who is to educate whom to their fullest usefulness?

The writer's position regarding all of these questions is that few can be answered outside the context in which a test is requested, given, and reported; a context which includes the theoretical orientation of the psychologist. If this is true, our greatest need is a recognition of the demand for greater flexibility and for caution against heavy investment in any one preferred technique until we experiment further to improve communication.

PUBLICATIONS BY MEMBERS OF THE STAFF

KLEIN, GEORGE S., SCHLESINGER, HERBERT J. and MEISTER, DAVID E.: The Effect of Personal Values on Perception: An Experimental Critique. *Psychological Rev.* 58: 96–112, March, 1951.

The experiment reported tests the influence of personal values on perception by means of a size estimation technique. The subjects, who included anti-Nazi refugee psychiatrists and native born clerical workers, were asked to judge the size of small discs some of which were blank, the rest being inscribed either with some neutral symbol or with a "value symbol," *i.e.* a dollar sign or swastika. The intent was to test more rigorously the increasingly popular hypothesis that personal values necessarily tend to "accentuate" or enhance the object perceived so as to cause it to be overestimated. A second purpose was to offer a methodological critique of this method of testing the influence of value on perception.

The main findings were: (1) the differences in error between the refugee and native-born groups could not be unequivocally attributed to the effect of value alone; (2) within each group of subjects, value and neutral figures were not judged significantly differently; (3) the factors which contributed grossly to error were difficulty of the task and the size of discs (the less optimal the conditions for judgment and the larger the disc, the greater the error); (4) certain subjects in both groups showed consistent tendencies either to overestimate or underestimate, independent of particular stimulus figures.

The divergence of these results from other reported findings, and the source of error they point to—that of testing the effect of personal values and motivations on perception, by a method that combines individual responses into a generalized average result—argue for re-conceptualizing, the problem, rooting it in the study of individual variations in perceptual organization and ego structure rather than solely in terms of conventional, generalized values.

HOLT, ROBERT R.: The Accuracy of Self-Evaluations: Its Measurement and Some of Its Personological Correlates. *J. Consulting Psychology* 15: 95–101, April, 1951.

Defining Insight as used in the article to mean "the degree to which self-evaluations are accurate," the author then discusses the problems in measuring it statistically. The obvious technique (correlation of ratings) proved unsuitable because its underlying assumptions were inappropriate; the measure adopted was the sum of squared deviations between a subject's self-ratings of 35 needs and criterion ratings by a Diagnostic Council.

The accuracy with which 10 college students rated themselves was found to be related to measures of *intelligence, active adventurous living in the world of reality, friendly dominance and social adjustments,* and (possibly) *constitutional strength.* Insight had a positive (though not significant) correlation with Projection in this group, a relationship which did not depend upon the desirability of needs rated and which did not disappear when the relationship of Insight and Projection to Organizing Intelligence was held constant. Most accurately rated by the group were dominant and

affiliative needs and only insignificant tendencies to overrate their most highly prized needs and to underrate distasteful ones were found. Greatest discrepancies in self-ratings and Council ratings seemed to be caused by defects in definitions of the variables.

KLEIN, GEORGE S., and SCHLESINGER, HERBERT J.: Perceptual Attitudes Toward Instability: I. Prediction of Apparent Movement Experiences from Rorschach Responses. *J. Personality* 19: 289–302, 1951.

This study experimentally defines a set of perceptual attitudes, resistance to and tolerance for instability and change in the perceptual field, reflected in Rorschach responses and in the experience of apparent movement (phi). The hypothesis holds that one expression of this attitude is the degree to which "reality testing" rigidly requires the "holding on" to forms as they are known to be, refusing to tamper with reality as given. Both the Rorschach situation and apparent movement provide an opportunity to see these attitudes in operation. Apparent movement is regarded as a "compromise" solution between the need to stabilize an ambiguous field and the knowledge that the stimuli are really stationary. The breadth of the range of exposure frequencies over which movement is seen should indicate readiness to accept such a compromise. Where ego controls unduly stress the preserving of a stable field the range and comfortableness of movement experience will be restricted.

Two groups of 10 subjects each (patients and staff of a psychiatric hospital) were selected according to Rorschach criteria of resistance and tolerance for instability and were tested for apparent motion. Apparent movement ranges were restricted in the group showing intolerance for instability. Closer inspection of the protocols for extreme subjects disclosed that frequency of response and quality of form were the most reliable *single* differentiators among the formal scores of the Rorschach; however, the general attitudes of ease of projection on the one hand and reluctuance to do so on the other were the most insistent qualitative themes. Similar perceptual attitudes toward instability seem to be operating both in the Rorschach and apparent movement situations. One implication of this, therefore, is that the Rorschach test lends itself to validation based on a rationale of *process* rather than upon "inkblot characteristics" alone.

BOOK NOTICES

Hypnodrama and Psychodrama. By J. L. MORENO and JAMES M. ENNEIS. $2.75. Pp. 56. New York, Beacon House, 1950.

This book would be much more effective if the authors made clear what they stood for rather than what they are against. It would seem that in the psychiatric armamentarium there is ample room for both psychodrama and psychoanalytic techniques. In common with his many other books, Dr. Moreno feels that he must demolish psychoanalysis before psychodrama can be accepted. The verbatim protocols are very interesting. (V. W. Bikales, M.D.)

Elements of Psychoanalysis. By HANS HERMA and GERTRUD M. KURTH. $3. Pp. 333. New York, World Publishing Co., 1950.

A collection of articles highlighting various aspects of psychoanalytic theory and practice. The contributors are well-known experts and many of the contributions are excellent. The volume as a whole is a well balanced presentation of problems of general interest. It is highly recommended as an introductory text. Unlike many elementary handbooks it also has a great deal to offer the more advanced student. (B. Rubinstein, M.D.)

Handbook for Volunteers in Mental Hospitals. By IDA JEROME DAVIES. Pp. 40. Minneapolis, University of Minnesota Press, 1950.

This handbook is designed for lay people who wish to start a program of service in their local state hospital. In very little space and in easy language, it covers the initial planning, recruiting, orientation and approach to patients. Miss Davies stresses that a volunteer should "try by warm friendship, respectful honesty, and dependability to give the patient a feeling of worth and self-confidence," that they should get all the technical information they can, but should leave diagnosis to the doctor. She urges fitting the right volunteer to the right job and recommends cautious screening of volunteers. The book should be valuable to anyone starting out to organize a volunteer program. (Mary B. Palmer)

Progress in Neurology and Psychiatry, Vol. V. E. A. SPIEGEL, ed. $10. Pp. 621. New York, Grune & Stratton, 1950.

This volume surveys over 3300 papers published during the year 1949. Sixty-four contributing editors have assisted in compiling a well-indexed, heavily documented compendium, alloting five chapters to basic neurology, nine to neurology, six to neurosurgery, and fourteen to psychiatry. Some topics are missing due to a policy of reviewing them only biannually. As a handy reference book with bibliographies at the end of each chapter, this will make a valuable addition to the practicing neuropsychiatrist's library. However, this reviewer finds it a little indigestible for an overall grasp of current progress. (L. Harold Caviness, M.D.)

Adler's Place in Psychology. By LEWIS WAY. $4.50. Pp. 334. New York, Macmillan, 1950.

This is a spotty exposition that attempts to satisfy both the layman and the scholar. It does neither, because it attempts to do both. Its better

sections are: the effects of the life style; Adlerian concept of social interest; and a lay discussion of child upbringing. Throughout there is a carping attack on "Freud's Pansexuality" which culminates in the indictment that "Freud sees neurosis from the neurotic's own angle; Adler from the angle of society" (p. 51). This book is mostly Lewis Way's philosophy, with an Adlerian flavor, rather than any significant clarification of "Adler's Place in Psychology." (Louis S. Cholden, M.D.)

Clinical Studies in Psychoanalysis. By SANDOR LORAND. $4. Pp. 272. New York, International Universities Press, 1950.

Eighteen of Lorand's clinical papers, published during the last twenty years in different clinical journals, are collected in this volume. This is a useful service since it makes these papers more accessible. Also, it discloses the wide range of Dr. Lorand's interests and his mastery of analytic thinking. One drawback of the book is that he did not write an introductory chapter in which he might have discussed the change in his thinking as it is reflected in these papers, the first of which appeared in 1929 when his teacher Sandor Ferenczi (to whose memory the volume is dedicated) was still alive. (Rudolf Ekstein, Ph.D.)

The Threshold of the Abnormal. By WERNER WOLFF. $6.50. Pp. 473. New York, Hermitage House, 1950.

Much material is presented in this book (subtitled "A Basic Survey of Psychopathology"), yet it is often too technical for the layman and not detailed enough for the practicing psychiatrist and psychologist. While dynamic in orientation (in fact, it is dedicated to Freud), some explanations of psychoanalytic concepts are not clear, others are over-simplified and many are defined in "psychoanalese." It might have been better to eliminate the sections on treatment, for these seem to serve little use in what the author calls a "survey of all known phases of the abnormal." The bibliographical material following each chapter is helpful. (Irving Kartus, M.D.)

The Diagnosis of Hysteria. By D. W. ABSE. $2. Pp. 912. Baltimore, Williams & Wilkins, 1950.

This little book is an account of the etiology, psychopathology, and clinical manifestations of hysteria. It does not purport to add to our knowledge of the genetics and dynamics of hysterical illnesses, and in fact provides only the bare framework of necessary analytic theory. It is written for the intending specialist in psychiatry and, although it cannot serve as a textbook on hysteria (since it is sketchy rather than comprehensive, anecdotal rather than systematic), it provides useful additional reading for the student. The clinical cases which form its basis were sick soldiers of the British and Indian armies in World War II. The contrasting pictures of anxiety hysteria in the Tommy and conversion hysteria in the Jawan are well-illustrated. (D. J. Watterson, M.D.)

The Other Side of the Bottle. By DWIGHT ANDERSON. $3. Pp. 258. New York, A. A. Wyn, Inc., 1950.

The author is a layman who has long been associated with medicine as Director of Public Relations, and later, Executive Secretary of the New

York State Medical Society. He is what he calls "a dry drunkard"; his account of the struggles and pitfalls of those subject to alcohol addiction is valuable for its readability, its convincing earnestness and the inspirational element implicit in his victory. (K. A. M.)

Recovery from Aphasia. By JOSEPH M. WEPMAN. $4.50. Pp. 276. New York, The Ronald Press, 1951.

This book marks the definitive entry of the aphasia therapist into the much neglected field of therapy for the aphasic patient. Toward the end that an adequate program for the rehabilitation of the aphasic must endeavor to deal with every facet of the personality—both physical and psychological—the speech pathologist, educator, and clinical psychologist are suggested as a team, together with the nurse and family, to help the patient recover all the language potentials. All of these, as well as the neurologist or psychiatrist, can benefit from this book. A brief but adequate review of the pertinent literature on aphasia is given, and the diagnosis of aphasic disorders and the detailed therapy of patients so afflicted are well-covered, utilizing experience gained during World War II. (Maurice N. Walsh, M.D.)

Psychotherapy. Rev. ed. By PAUL SCHILDER. $5. Pp. 396. New York, Norton, 1951.

Schilder's classic has been brought out in an attractive new edition, revised and enlarged by Lauretta Bender. As in the first edition, 1938, nearly all aspects of psychological medicine are discussed in their relationships to psychotherapy. Schilder believes that scientific psychotherapy began with Freud, but he disagrees with some of Freud's basic concepts. It is Schilder's opinion that it is not indispensable for psychotherapists or even analysts to be psychoanalyzed, and that there is danger of the therapist becoming too much imbued with the principles and techniques of the man who analyzes him, with the result that too rigid techniques may be handed down from one analyst to the next generation. (Albert Owers, M.D.)

Hypnosis: Theory, Practice and Application. By RAPHAEL H. RHODES. $3. Pp. 176. New York, Citadel Press, 1950.

According to Rhodes, his "theory of Psychic Relative Exclusion" is "the most comprehensive explanation of all psychological phenomena manifested by individuals while awake, asleep, or hypnotized" and explains "the reason *why* the Freudian psychoanalytic technique works . . ." The theory: every person has two minds, "the objective and the subjective," which are "in a relative state of see-saw balance"; the "objective mind" reasons inductively and deductively, the "subjective" only deductively. This oversimplified formulation hardly warrants the name "theory" and *explains* little. (Gerald A. Ehrenreich)

Biological Foundations of Health Education. Proceedings of the Eastern States Health Education Conference, 1948. $2.50. Pp. 169, New York, Columbia University Press, 1950.

Sponsored by the New York Academy of Medicine, this conference consisted of a group of essays on nutrition, psychiatry, gerontology and

epidemiology. The theme of the essayists was directed toward the teaching techniques and psychological motivations best suited to disseminate public health information to receptive audiences. The psychiatric contributions are by Paul Lemkau and George S. Stevenson. Ethel L. Ginsburg gives a most eloquent portrayal of the contribution of the psychiatric social worker to this goal. (D. Bernard Foster, M.D.)

Fostering Mental Health in Our Schools. 1950 Yearbook, Assn. for Supervision and Curriculum Development. $3. Pp. 320. Washington, D. C., National Education Assn., 1950.

The University of Chicago Committee on Human Development and others from the Chicago area were contributors in organizing and developing the material in this book. It is surprising for a book which has so many contributors that the level of material is of such excellent quality.

The material is set up in three parts. The first is devoted to factors determining behavior and development. The second part deals with the child's motivation and is to this reviewer the best portion of the entire book. The sympathetic presentation of this aspect of education should carefully be read by all educators. The third part is concerned with knowing and helping the child and will interest those in the field of child psychology and child psychiatry. (Edward D. Greenwood, M.D.)

Neurosis and Human Growth. By KAREN HORNEY. $3.75. Pp. 391. New York, Norton, 1950.

Typical for this book is the undertitle: "The Struggle Toward Self-Realization." The vagueness of this expression together with its cheap suggestion of depths and mystic glory condense beautifully what the courageous reader has to expect on its way through the 398 pages. Any doubt as to the emptiness of this verbose production will be removed forever by Chapter 14, "The Road of Psychoanalytic Therapy," where every hint at what the so-called therapy may consist of is thoroughly avoided. (Hellmuth Kaiser, Ph.D.)

A Rorschach Training Manual, ed. 3. By JAMES A. BRUSSEL, KENNETH S. HITCH and ZYGMUNT A. PIOTROWSKI. $.75. Pp. 86. Utica, N. Y., State Hospitals Press, 1950.

This is an enlarged third revision of a second edition published in 1947 as "Rorschach Compendium," consisting of two papers. "An Introduction to Rorschach Psychodiagnostics in Psychiatry" by Brussel and Hitch is essentially a testimonial to the diagnostic usefulness of the test. The second paper, Piotrowski's "Rorschach Compendium," after summary comment on the history and a few theoretical references, defines the various scoring categories of the test as they are conceived and used by the author. It is regrettable that assumptions, rationale, interpretive speculation are undifferentiated. Too meager for introductory teaching and too elementary for advanced students, when used alone, it is recommended as supplementary reading by all Rorschach students. (Walter Kass)

Neurosis and Psychosis. By BEULAH CHAMBERLAIN BOSSELMAN. $4.50. Pp. 172. Springfield, Ill., Charles C. Thomas, 1950.

The author utilizes the genetic-dynamic approach in this text, which deals briefly but well with the various psychopathic states with emphasis on their meaning and treatment. It could be a better text for the medical student for whom it is intended if it dealt more comprehensively with some of the disorders and particularly the field of psychosomatic medicine which is disposed of in a few pages. (Henry Lihn, M.D.)

The "Why" of Man's Experience. By HADLEY CANTRIL. $2.75. Pp. 198. New York, Macmillan, 1950.

Cantril offers a penetrating account of an empiricist's view of man's behavior. Bearing the conspicuous stamp of Helmholtz and Ames, his book develops the doctrine that "mind" has its beginnings and growth in individual experience. Hypotheses and assumptions compose our personal world. This "assumptive form world" is the only one we know and since it is knowable only through personal experience it is different for each person. Cantril derives from these propositions consequences for a theory of perception and action; there are provocative implications for the problem of particulars and universals, problems of ethics, and social and political values. (Philip S. Holzman)

The Psychoanalysis of Elation. By BERTRAM D. LEWIN, M.D. $3. Pp. 200. New York, W. W. Norton, 1950.

After a lucid survey of the literature on elations and depression, both from the descriptive and dynamic standpoints, the author offers a very careful formulation of what he considers to be the basic factors operative in elation and its variants. Of particular interest are the importance of elation as a defense mechanism, and Lewin's addition to the theory of oral eroticism with emphasis on the wish to be devoured and the wish to sleep (hitherto given insufficient attention) which later become transformed into a fear of death and a wish to die. An excellent bibliography and index complete this important contribution to the understanding of other phenomena of psychic experience as well as elations. (M. Lozoff, M.D.)

The Transmission of Nerve Impulses at Neuroeffector Junctions and Peripheral Synapses. By ARTURO ROSENBLUETH. $6. Pp. 275. Published jointly by the Technology Press of Massachusetts Institute of Technology and John Wiley & Sons, New York, 1950.

A well balanced and readable monograph by an individual of singular knowledge, experience and interest in neural transmission. He presents a comprehensive review of available data on the chemical theory of synaptic transmission gleaned from abundant personal laboratory experience and the literature, and amply documented by graphic illustrations. This book is especially useful to the physiologist and particularly the neurophysiologist and offers stimulating reading for the clinical neurologist and neurosurgeon. (John A. Segerson, M.D.)

Projective Psychology. By LAWRENCE E. ABT and LEOPOLD BELLAK. $6. Pp. 485. New York, Knopf, 1950.

The editors, in their introductory chapters, have made an ambitious attempt to redefine the concept of projection and to reconcile it with general psychology as well as with psychoanalysis. Bellak's demonstration that projection can be explained in terms of association, learning, and apperception is valuable. The effect is somewhat confused, however, by Abt's designation of projective psychology as "the psychology of revolt" and by his effort to make it a system in its own right. The remainder of the book includes chapters by specialists in some of the better projective techniques. (Helen D. Sargent, Ph.D.)

Understanding Natural Childbirth. By HERBERT THOMS in collaboration with LAURENCE G. ROTH and DAVID LINTON. $3.50. Pp. 112. New York, McGraw, 1950.

This book should be read, not only by prospective parents, but especially by those who determine and carry out hospital procedure. It describes the logical, modern way to start young parents and their babies on the road to physical and mental health. The author has found that informing the mother of the physiology of the birth process and redefining the role of the father, doctor, and hospital, dispenses with fear and loneliness for her, and helps make childbirth a gratifying and normal experience. (Marjorie M. Lozoff)

Dementia Praecox or the Group of Schizophrenias. By EUGEN BLEULER. $7.50. Pp. 548. New York, International Universities Press, 1950.

Dr. Joseph Zinken translated this volume from the German, giving us our first English edition, although the original work appeared in 1911. He was encouraged in his efforts by Dr. Gregory Zilboorg, Dr. Nolan D. C. Lewis, and Dr. Paul Hoch. Dr. V. T. Davis, Dr. Robert H. Felix, and various members of the U. S. Public Health Service were interested in and aided the undertaking. Gerda Corvin, Lottie Maury, Milan Stoeger, and the translator's wife, Lillian W. Zinkin, cooperated in various ways. In this list we have a new honor roll for psychiatry and psychology. They have done these professions an enormous service. (Milton Wexler, Ph.D.)

Carbon Dioxide Therapy. By L. J. MEDUNA. $5. Pp. 236. Springfield, Ill., Charles C. Thomas, 1950.

A presentation of this method of treatment for certain psychoneuroses and character disorders is well made. Divisions of the book—a historical review of the use of carbon dioxide, its physiological effects, the technique of administration, and statistical data—are useful and understandable. The objectively presented case studies contribute to an understanding of the technique and the indications and contraindications regarding its use. Almost one quarter of the book is devoted to the author's "neurophysiological theory of psychoneurosis," which may be accepted or rejected without creating bias as to the worthiness and desirability of continued research in the application of this treatment. (Jack Dunagin, M.D.)

Principles of Intensive Psychotherapy. By FRIEDA FROMM-REICHMANN. $3.75. Pp. 246. Chicago, Univ. of Chicago Press, 1950.

Fromm-Reichmann's book is the fruit of her many years' experience in long-term, intensive psychotherapy, particularly with psychotics. Treatment of the subject is thorough and rewarding for both beginner and expert. Her clearly stated points are well illustrated with case histories. Theoretically, she hews to the line of Harry Stack Sullivan's interpersonal concepts, and therefore rejects much that is basic in psychoanalysis. (Herbert C. Modlin, M.D.)

Theory of Mental Tests. By HAROLD GULLIKSEN. $6. Pp. 486. New York, John Wiley & Sons, 1950.

The author frankly admits that his volume is intended mainly for use by those working in the field of test development. To obtain maximum understanding of what the author has to offer, the reader must be able to manipulate freely equations in algebra and analytical geometry. Gulliksen brings together in one volume his experience as a teacher and as director of a war research project in test development for the Bureau of Naval Personnel. It should serve well as a reference text for psychologists who have research interests. (John W. Chotlos, Ph.D.)

The Psychology of Mental Health. By LOUIS P. THORPE. $5. Pp. 747. New York, The Ronald Press, 1950.

This is an orientation book for undergraduates, reviewing the scope and nature, theory and methods of the mental health disciplines. There is a clear but elementary explanation of concepts and historical controversies in the mental health field. The book, however, relies heavily on classifications that tend to become lists and diagrams used as a substitute for theory and offers little experimental or clinical evidence to support its conclusions. Psychoanalysis is gratefully, but begrudgingly, recognized and incorrectly regarded as minimizing social, developmental, organic and psychological factors in mental illness. (Jerry Osterweil)

Mathematical Biology of Social Behavior. By NICHOLAS RASHEVSKY. $5. Pp. 256. Chicago, University of Chicago Press, 1951.

In an initial summary of the mathematical biophysics of the central nervous system, the author sets up mathematical postulates and equations which are interpreted in terms of neurobiophysical concepts. These are applied to three phases of social behavior, imitation, motivation, and learning, retaining the neurological frame of reference, and to other miscellaneous social problems, including that of social hierarchies, without the neurological basis. The author takes pride in *using* mathematics throughout, instead of merely talking about it. Understanding his work, which often reads like a mathematical textbook, presupposes a working knowledge of differential and integral calculus and theory of functions together with a grounding in psychology, sociology, and neurological concepts. (Lolafaye Coyne)

Childhood and Society. By ERIK H. ERIKSON. $4. Pp. 397. New York, Norton, 1950.

A really illuminating new book is a rare and exciting event; *Childhood and Society* is such a book.

Integrating (rather than combining) the insights of psychoanalysis and anthropology, and applying the principles of psychoanalysis throughout, the book treats of such questions as these: eight crucial phases of personality development from babyhood to maturity; the theory of infantile sexuality in relation to social organization and social upheaval (and many sidelights on psychopathology); the moulding of "national character" through specific ways in which societies both help to create and systematically exploit infantile anxieties in its members; why has psychosomatic illness become so dominant of late?; what is the basic query which American patients of today bring to their analyst?; reflections on the American identity and on the problems confronting American youth; psychoanalysis as a science and as a tool of human betterment.

The book as a whole can be described as forceful, original, imaginative, clinical, thoughtful, sensitive, humorous and deeply humane. (Sibylle Escalona, Ph.D.)

The Treatment of Acute Craniocerebral Injuries Due to Missiles. American Lecture Series, No. 22. By DONALD D. MATSON. $1.85. Pp. 90. Springfield, Ill., Charles C Thomas, 1948.

This is a most succinct compilation of information gained in the handling of head injuries in World War II by neurosurgeons in the American and British armies. A competent general surgeon familiar with this book should be abe to handle adequately most military head injuries. (James B. Campbell, M.D.)

The Energetics of Human Behavior. By G. L. FREEMAN. $3.50. Pp. 344. Ithaca, N. Y., Cornell University Press, 1948.

Freeman has made an impressive attempt to integrate many years of objective physiological experimentation into a comprehensive theory of human behavior, the central principle of which is that "all behavior is an attempt to preserve organismic integrity by 'homeostatic' restorations of equilibrium." The student of personality will be primarily interested in his discussion of learning, motivation, personality differentiation (he postulates "tension discharge types" which have much in common with some classifications based upon defensive mechanisms), behavior disorders, and psychotherapy. Among the book's strong points are the author's avoidance of considering the organism a closed energy system, and his care in distinguishing between cross-sectional and longitudinal analyses of the hierarchical organization of homeostatic processes which comprise the human energy system. (Riley W. Gardner)